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Authors' reply

We write on behalf of our coauthors¹ to agree with Jacques van Helden and colleagues that scientists “need to evaluate all hypotheses on a rational basis, and to weigh their likelihood based on facts and evidence, devoid of speculation concerning possible political impacts”. Scientific knowledge is essential to effectively guide future efforts to reduce the chance of another pandemic,^{1,2} including by mitigating or blocking all relevant pathways for a pathogen to host-shift from natural hosts to humans. Endless arguments back and forth about the emergence of SARS-CoV-2, pitting evolution and spillover in nature against a laboratory leak do little to advance our critical knowledge base. We need more scientific evidence that unravels the likely pathway for the virus because real evidence that confirms or refutes hypotheses is far more important than the hypotheses and conjectures themselves. Expert reviews and new data continue to emerge tracing the evolutionary pathway of SARS-CoV-2 in nature over decades, serving to place some controversial genomic characteristics

within a broader evolutionary context.³⁻⁵ However, while we need more evidence, the world will remain mired in dispute without full engagement of China, including open access to primary data, documents, and relevant stored material to enable a thorough, transparent, and objective search for all relevant evidence. As we have already seen⁶ this engagement is impossible in an environment of implicit or explicit blame placed on the Wuhan Institute of Virology and its scientists. We stand by our statement that “recrimination has not, and will not, encourage international cooperation and collaboration”.¹

JSM is a member of the WHO International Health Regulations Emergency Committee for COVID-19, a member of the One Health High Level Expert Panel that advises the Food and Agriculture Organization of the UN, the World Organisation for Animal Health, the United Nations Environment Programme, and WHO, and a past member of the scientific advisory committee for the Center for Emerging Infectious Diseases of the Wuhan Institute of Virology (2008–11). JSM has past or ongoing academic and scientific collaborations on coronavirus biology with colleagues in China and several other countries. GTK, SKL, and LS are members of the Lancet Task Force on the Origins and Early Spread of COVID-19 & One Health Solutions to Future Pandemic Threats. MT declares no competing interests.

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Telehealth use in antenatal care? Not without women's voices

Kirsten R Palmer and colleagues¹ assessed integrated telehealth for antenatal care in Australia during the early COVID-19 pandemic. However, the estimated 50% reduction of in-person consultations does not represent the proportion of telehealth consultations received by women. Women included in the intervention gave birth between March 23 and July 26, 2020, which is equivalent to, at most, 4 months of a telehealth-integrated antenatal care schedule. Although not presented, the average duration of antenatal follow-up was probably 2 weeks (implementation period) and 6 weeks (integrated care period), allowing for a maximum of two telehealth visits with three face-to-face consultations. This limited exposure at the end of pregnancy is unlikely to show significant differences in outcomes and we are concerned that the conclusion of no compromise to pregnancy outcomes is premature. We need rigorous studies assessing the implementation of telehealth in comparison with a face-to-face model throughout the entire pregnancy.

Furthermore, the investigators' recommendation to adopt telehealth beyond the pandemic fails to consider dimensions of care quality and equity.

Research shows that care quality is compromised by incorporating telehealth into routine maternity care.^{2,3} High user satisfaction rates with telehealth should be interpreted within the context of the pandemic's restrictive measures and women's intent to reduce the risk of SARS-CoV-2 infection, because qualitative evidence shows that pregnant women who received telephone consultations felt distressed due to scarce face-to-face contact with health-care providers.⁴ More research is needed on women's perspectives of respectful and quality care during any antenatal care schedule that uses telehealth. Additionally, relying on telehealth can contribute to exacerbating inequalities in maternal health,⁵ in which financial barriers, technological illiteracy, and mistrust lead to excluding vulnerable women.²

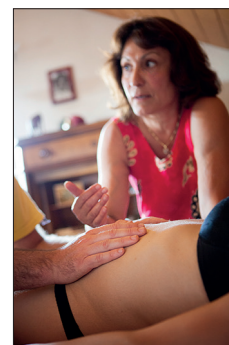
Although Palmer and colleagues show that partial use of telehealth in antenatal care appeared to be a non-inferior alternative to prevent disruption of care during the period of COVID-19 restrictions in the Australian context, unjustified compromises to high-quality, person-centred, and equitable care should not be acceptable as a way forward.

We declare no competing interests.

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